JUST WHAT THE DOCTOR ORDERED? IS NEVADA’S APPROACH TO SOLVING ITS MEDICAL
MALPRACTICE CRISIS A PROGRESSIVE TREATMENT OR AN ILLUSORY BAND-AID? A
CRITICAL REVIEW OF AB 1

Statutes Affected: NEV. REV. STAT. 1.360; 7.085; 41.505; 41A.003; 41A.097;
41A.100; 42.020; 49.245; 630.130; 630.267; 630.3062; 630.307;
630.364; 633.471; 633.511; 690B.045; 690B.050.

Statutes Repealed: NEV. REV. STAT. 41A.0043; 41A.005; 41A.008; 41A.016;
41A.019; 41A.023; 41A.024; 41A.026; 41A.029; 41A.033;
41A.036; 41A.039; 41A.0.143; 41A.046; 41A.049; 41A.0 51;
41A.053; 41A.056; 41A.059; 41A.069; 631.377.

Adds new sections to NEV. REV. STAT. Chapters 3, 41
41A, 439, 449, 630, 633.

Stat. 3.

I. Introduction

Assembly Bill 1 of the Eighteenth Special Session (“AB 1”) marked a monumental change in Nevada’s regulation of medical malpractice disputes. The most controversial piece of the legislation caps the amount of noneconomic damages available to a plaintiff in a civil suit against his or her health care provider, subject to two exceptions. Senator Perkins labeled the caps “the cornerstone of the entire issue of medical malpractice reform.” These caps were meant to remedy what Nevada considered a crisis due to the exodus of physicians from Clark County. In theory, the caps were an effort to keep insurers of health care providers in Nevada by limiting the economic amount for which doctors could be liable. Although legislators felt that it may not be a perfect system, they felt it was the best and only choice presented in light of the escalated concerns from all citizens of Nevada. By the end of the Eighteenth Special Session, the legislature had prepared a reform that was meant to appeal to insurers, physicians, and those citizens in fear that they would not be fully compensated if they were seriously injured by their physician’s malfeasance.

The bill also made other important changes: it eliminated the Medical and Dental Screening Panel, it shortened the statute of limitations for a malpractice claim, it requires pretrial conferences, regulates expert testimony, requires training for district court judges who try malpractice cases, and requires physicians and dentists to carry malpractice insurance with minimum limits. It also requires the Board of Medical Examiners to submit periodic reports on disciplinary actions and malpractice cases, and requires physicians and dentists to report

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1 By Jason Revzin, J.D. Candidate Fall 2003.
3 See generally Assemb. B. 1,18th Spec. Sess. (Nev. 2002).
malpractice claims. While important, these issues will not be discussed in detail in this article because they passed into law with moderate to limited debate. Instead, this article will focus on noneconomic damages caps and how they will affect the future of medical liability in Nevada.

II. The Clark County Health Care Crisis of 2002

AB 1’s enactment, although expedient, was not surprising. The Nevada legislature acted in the midst of what it called a health care “crisis.” Several years before the bill was enacted, both physicians and their insurers were becoming increasingly nervous because the number of medical malpractice claims being filed was steadily escalating. Clark County saw 133 medical malpractice lawsuits filed in 1998, 148 in 1999, and 158 in 2000. Not only was the number of cases increasing at an alarming rate, but the verdicts handed down in medical malpractice cases were becoming astronomical. For example, in Ruppert v. Buzard, the plaintiff sued his physician after treatment lead to total blindness in one eye, causing him to undergo subsequent medical procedures. The jury awarded a $2 million dollar verdict, the largest award in 2000. The Ruppert case was not the only decision in 2000 that resulted in a verdict in excess of one million dollars. The second largest verdict of 2000 came in Fowler v. Egtedar, when the jury concluded that a physician’s failure to timely diagnose the plaintiff’s fractured femur caused her to suffer permanent nerve damage, and awarded her $1,237,220. In Marquez v. Southwest Medical, a jury awarded the plaintiff $1.2 million after determining that the physician failed to timely diagnose the plaintiff’s facial fractures, which resulted in permanent nerve damage and complex surgical repair.

While the medical malpractice verdicts of 2000 caused many physicians and insurers to sweat, the amount of money awarded that year turned out to be peanuts compared to the verdicts rendered in 2001. In Watts v. Reliable Medical Care, the jury awarded the plaintiff $6 million, one of the largest medical malpractice verdicts in Nevada’s history. The plaintiff was a child who claimed that his problematic birth devastated his physical and mental development, leaving him permanently unable to walk and stuck at the intelligence level of a one-year old child. A high-dollar verdict was also rendered in Banks v. Sunrise Hospital, where the jury awarded $5,412,031 to a fifty-one -year old now in a persistent vegetative state (the jury decided it would cost $14,000 per month just to keep the plaintiff alive). In Debourg v. Southwest Medical, jurors only had to deliberate one and a half hours before awarding $4.6 million to a plaintiff who claimed that a nurse practitioner’s failure to diagnose a cervical cord compression caused

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4 Id. at § 38.
7 Id.
8 Babula, supra note 5.
10 Id.
permanent damage to the nerves in her arms and legs.\textsuperscript{15} Furthermore, the fact that the decedent in \textit{Conn v. Schiff}\textsuperscript{16} was seventy years old did not prevent a jury from awarding $2 million to his family when they brought suit on his behalf, arguing that a doctor at Summerlin Hospital sent him home even though an electrocardiogram showed abnormal results.\textsuperscript{17} These are just a few of the large jury verdicts rendered in 2001.

Inevitably, the result of these rather large verdicts, and the number of medical malpractice cases being filed, began to reflect in insurance premiums. Physicians performing high risk procedures on patients with health problems affecting their brain, heart, or complicated pregnancies were paying over $100,000 per year in insurance premiums.\textsuperscript{18} In 2001, St. Paul, Nevada’s largest insurer of health care providers at the time, insured over 1,300 physicians in Nevada, including 900 from Clark County.\textsuperscript{19} St. Paul attracted a large percentage of physicians in Clark County based on its competitive premiums, which were often lower than the leading providers, and its general acceptance of high-risk physicians who might have trouble obtaining insurance elsewhere. However, St. Paul began to feel the hit from offering lower rates. The company spent $3.5 million defending doctors in 1995; by 1998, this number rose to an astonishing $23.2 million.\textsuperscript{20} This left St. Paul feeling that it had to either increase premium rates or be forced to leave the state. In mid-2001, it asked the Nevada Commissioner of Insurance, Alice Molasky-Arman, for an eighty-four percent increase in rates, the highest request the company made in all of the thirty-eight states it operates in.\textsuperscript{21} However, in December of 2001, St. Paul decided to pull out of the market nationwide and stopped offering medical malpractice insurance.\textsuperscript{22} Andrea Wood, a spokesperson for the company, claimed that the company paid out an average of $2 in losses for every $1 it collected from Nevada doctors between 1996 and 2001.\textsuperscript{23} The pullout left many health care providers scrambling to find other coverage, most of which they couldn’t afford.\textsuperscript{24}

By early 2002, over thirty Las Vegas obstetricians had left town or stopped delivering babies because they either could not find medical malpractice insurance or could not afford the inflated rates, leaving only about eighty doctors available to deliver babies.\textsuperscript{25} While this fact began to alarm many citizens in the county, the real impact came a few months later, in June, when five trauma surgeons and twenty-six specialty surgeons resigned or requested leave from Las Vegas’s only trauma center, University Medical Center, claiming it was too risky to continue

\textsuperscript{16} No. 00-A-415376-C (D. Nev. filed Feb. 23, 2000).
\textsuperscript{18} Babula, \textit{supra} note 5.
\textsuperscript{19} Id.
\textsuperscript{20} Id.
\textsuperscript{21} Id.
\textsuperscript{23} Id.
\textsuperscript{24} Id.
to do business with insurance rates being so high.\textsuperscript{26} The doctors who resigned claimed that the only thing that would bring them back was a change in the medical malpractice laws in Nevada, and urged the legislature to adopt a system similar to California’s $250,000 cap on civil damages.\textsuperscript{27} This exodus of doctors caused UMC to close its doors on July 4, 2002 because it did not have enough physicians to staff the facility.\textsuperscript{28} This caused panic because the trauma center saw more than 11,000 patients a year from Nevada and other states, such as California, Arizona, and Utah, and helped victims of severe car accidents, major falls, and knife and gunshot wounds.\textsuperscript{29} After assurance from members of the legislature that a reform was on its way, several of the doctors returned to the UMC trauma center under temporary employment contracts, which allowed the unit to open its doors again on July 14, 2002.\textsuperscript{30}

The pressure on the Nevada legislature was unquestionably mounting, and action had to be taken. On July 26, 2002, Governor Kenny Guinn met with members of both houses of the Nevada legislature and officially called a Special Session to resolve the medical malpractice crisis.

\textbf{III. Analysis of AB 1}

\textbf{A. The $350,000 Cap on Noneconomic Damages}

One of the most unpredictable parts of a medical malpractice case is the jury’s award for noneconomic damages, or pain and suffering. It is inherently difficult for juries to place monetary value on exactly how much a victim should be compensated for the amount they have suffered. As a result, the amount of money awarded varies greatly from case to case, with extremely large amounts being awarded, as demonstrated in some cases above. These unpredictable verdicts make it difficult for insurers to underwrite policies with low premiums because, in any given case, a physician could be socked with large amounts of financial liability. Therefore, the purpose of the $350,000 damages cap, proposed by Governor Kenny Guinn, was to stabilize the medical liability insurance market by giving insurers the confidence that only the most egregious medical malpractice cases would lead to a verdict in excess of $350,000.\textsuperscript{31}

The language of AB 1 (now \textsc{Nevada Revised Statute} 41.031) that has caused so much controversy is modestly succinct and reads in pertinent part:

\begin{quote}
Except as provided in subsection 2 [gross negligence, and exceptional circumstances exceptions] and except as further limited in subsection 3 [several liability exception], in an action for damages for medical
\end{quote}


\textsuperscript{29} \textit{Id.}.


malpractice or dental malpractice, the noneconomic damages awarded to each plaintiff from each defendant must not exceed $350,000.\textsuperscript{32}

One of the concerns about the damages cap is that plaintiffs and their families will not be fully compensated for the injuries they suffer as the result of a negligent doctor. These concerns were vividly expressed to the legislature during the Assembly’s first meeting on July 29, 2002. For example, Susan Roe, a testifying witness, voiced her concern through an emotional story about her son who was diagnosed with acute lymphocytic leukemia at the age of fourteen:

Mrs. Roe stated her son suffered greatly and died unnecessarily as a result of their physician’s negligence. Her family had been advised to follow a treatment protocol that was thought to be a better option for Christopher. . . . With sadness in her voice, Mrs. Roe explained that the final pathology report had not been examined, and, as a result of that oversight, the less aggressive path of treatment was selected for Christopher. He died within 9 months.\textsuperscript{33}

Mrs. Roe’s personal research had revealed that the physicians had ignored signs and symptoms present at the time of diagnosis that would have dictated cranial radiation therapy in addition to chemotherapy.\textsuperscript{34} She believed that litigation was the family’s only recourse and the most effective means to send an important message to the physicians.\textsuperscript{35} Mrs. Roe felt that if the cap of $350,000 were enacted, it would be almost impossible to locate an attorney willing to take the case, and that ordinary citizens would be denied access to the justice system.\textsuperscript{36} Additionally, if there were no cases proceeding to court, there would be no mechanism to deal with incompetent physicians.\textsuperscript{37} Finally, Mrs. Roe stated that one of her son’s physicians admitted his awareness of the error one month after the point of Christopher’s diagnosis.\textsuperscript{38} In her view, that was an egregious act of malpractice and denied her son a chance at survival.\textsuperscript{39} Her case was pending before the Screening Panel, and she was afraid that the new legislation would prevent families in similar situations from being fully compensated.\textsuperscript{40}

The National Trial Lawyers’ Association (NTLA) was perhaps the biggest organized opponent of the proposed reform. On the second day of the Assembly Meeting, the NTLA showed a powerful videotape portraying three distinct cases and summarizing the testimony of patients and their families who were affected by medical malpractice.\textsuperscript{41} The first case portrayed a gentleman who went to a doctor for a needle biopsy of the chest. The patient complained that he was having problems breathing, but the doctor’s response was that the patient should “suck it up” because they were almost done. The end result was that the aorta had been punctured several times and the patient died as a result.\textsuperscript{42}

The second case was about a baby who was born at full term. The mother of the child stated she had asked the doctor if she could have a caesarean section to which the doctor replied

\textsuperscript{32} Assemb. B. 1, § 5,18th Spec. Sess. (Nev. 2002); NEV. REV. STAT. 41.031 (2003).
\textsuperscript{34} Id.
\textsuperscript{35} Id.
\textsuperscript{36} Id.
\textsuperscript{37} Id.
\textsuperscript{38} Id.
\textsuperscript{39} Id.
\textsuperscript{40} Id.
\textsuperscript{42} Id.
he preferred to induce labor. As a result, the baby was born not breathing, had a seizure, and severe life-long problems had occurred.  

The third case involved a patient whose husband had taken her to the emergency room; she was the only patient there at the time. She stated she was very ill and could not get the attention of anyone to assist her. After examination, she was diagnosed with a small kidney stone, given some medication and sent home. Just more than a week later, she had lost her legs and her doctors had considered taking her hands as well.

On the other side of the issue, there was also a good deal of testimony supporting a damages cap reform. Reverend Chester Richardson supported the damages cap because his son’s life had been saved by treatment at UMC after he was injured during a drive-by shooting; this could not have occurred without the service of the doctors. Also, Bill Welch, President and Chief Executive Officer of the Nevada Hospital Association, stated that his association supported the passage of the tort reform because it would help alleviate the current crisis; he backed this contention with supporting data.

The end result was a $350,000 monetary cap on the amount of noneconomic damages that could be awarded at trial, and a $50,000 cap on both economic and noneconomic damages for a physician who renders emergency care to a patient. The difference between economic and noneconomic damages is simple, yet important. Economic damages are defined as damages for medical treatment, care or custody, loss of earnings and loss of earning capacity. They are those damages that represent out-of-pocket expenses needed for care of an injured victim plus the expense associated with their loss of ability to earn a living and the loss of wages during their injury and recovery periods. Noneconomic damages, on the other hand, are broken down into past and future damages of pain and suffering, inconvenience, physical impairment, and disfigurement. Past damages, whether economic or not, represent the damages inflicted upon a patient from the time of the medical malpractice until the time of the trial. Future damages include those from the end of the trial through the anticipated life expectancy of the victim.

A few points are worth mentioning here, although they will be addressed in greater detail below. First, the Legislature chose to cap only noneconomic damages, not all damages in general. As will be explained, some states that have enacted medical liability reform laws have capped all damages, both economic and noneconomic. This shows at least some effort on the part of lawmakers to limit the amount of unfairness to plaintiffs. Second, Nevada allows for two exceptions to the caps, one for gross negligence committed by the physician, and the other for situations that the judge, through clear and convincing evidence, deems exceptional circumstances. In this regard the plaintiff is allowed an opportunity to challenge the verdict.

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43 Id.
44 Id.
45 Id.
46 Id.
47 Id.
54 Id.
which gives the system some flexibility. Finally, the amount capped is $350,000, which is larger than some other states, thus giving the plaintiff a slight advantage in Nevada.

**B. The $50,000 Cap on All Damages Occurring During Emergency Treatment**

NEVADA REVISED STATUTES section 41 was amended by AB 1 to include the following language:

1. Except as otherwise provided in subsection 2 and NRS 41.505:

   (e) A physician or dentist licensed under the provisions of chapter 630, 631 or 633 of NRS:
   
   (1) Whose liability is not otherwise limited pursuant to NRS 41.032 to 41.0337 inclusive; and
   
   (2) Who renders care or assistance in a hospital of a governmental entity that has been designated as a center for the treatment of trauma . . . that in good faith renders care or assistance necessitated by a traumatic injury demanding immediate medical attention, for which the patient enters the hospital through its emergency room or trauma center, may not be held liable for more than $50,000 in civil damages, exclusive of interest computed from the date of judgment, to or for the benefit of any claimant arising out of any act or omission in rendering that care or assistance if the care or assistance is rendered in good faith and in a manner not amounting to gross negligence or reckless, willful or wanton conduct.  

This provision provides a cap of $50,000 irrespective of whether the damages were economic or noneconomic in nature. The provision does not consider fault or degree of damages. For the cap to apply, the medical care would have to be delivered in good faith and in a manner that did not result in gross negligence or reckless conduct. The clear rationale for this part of the bill was to avoid situations such as those encountered in July of 2002 when UMC temporarily closed its doors. This rationale is reinforced by another provision of AB 1 which provides total immunity from liability to physicians who render treatment in a health care facility of a government entity or a nonprofit organization so long as the care was given gratuitously, in good faith, and does not amount to gross negligence or reckless, willful or wanton conduct.

**C. The Gross Negligence Exception**

Under the new law, when a medical malpractice case goes to a jury for a verdict, the jury will not be instructed on the $350,000 noneconomic damage cap, allowing the jury to reach whatever verdict it deems just. If the verdict’s amount for pain and suffering exceeds $350,000, the judge will reduce the award to the damage cap. However, in the interim, the plaintiff’s lawyer may file a post-judgment motion (and of course the defendant may file an opposition to this motion) to argue that the judge should not cap the award, based on one of the exceptions, such as gross negligence. However, this is much easier said than done, because there is at least some uncertainty as to exactly what conduct amounts to gross negligence or malpractice. AB 1 defines gross malpractice as:

...[a] failure to exercise the required degree of care, skill or knowledge that amounts to:

   (a) A conscious indifference to the consequences which may result from the gross malpractice; and

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56 Id. at § 1.5.
58 Id.
(b) A disregard for and indifference to the safety and welfare of the patient.\textsuperscript{59}

Surprisingly, there was little discussion in either the Assembly or the Senate regarding issues of exactly what conduct amounts to “gross malpractice.” Perhaps this was because the term is expressly defined in the statute itself, or perhaps it was because nobody is quite sure because the issue rarely came up in litigation. Gerald Gillock, of the NTLA, opined that he never saw gross malpractice alleged in his cases because it was an almost impossible standard to meet.\textsuperscript{60} He clarified that “gross malpractice goes to the act and not the consequences of the act,” and that it was basically a complete absence of any care.\textsuperscript{61} The issue is always what the doctor did or did not do as opposed to what happened.\textsuperscript{62}

If gross negligence was not a big issue before AB 1, it is certain to become a new buzzword in its aftermath. As more and more jury verdicts come in excess of the damages cap forcing plaintiffs’ lawyers to file post verdict motions, whether or not a physician’s conduct constituted gross negligence will be a hotly debated topic. As Mr. Gillock points out, it was never argued before, but this is simply because lawyers never needed to argue it before; attorneys could get large verdicts by proving mere negligent conduct. Why would any attorney argue gross negligence, which requires a high standard of disregard for one’s health, when he could just argue negligence or that the doctor’s treatment fell below the standard of care? Now, in order to maximize the amount of damages for their clients, attorneys will be forced to argue that the exception to AB 1 should be applied because it meets the bill’s definition. Because there is no case law on the subject, the judge will have some discretion in determining when to apply the exception.

Whether this will create a giant loophole in the system is quite questionable. As Mr. Gillock mentioned above, the gross negligence standard has a connotation of being a near “impossible” standard to meet. It would be a stretch to conclude that judges will unexpectedly apply the standard to cases in which it would not have prior to AB 1.

However, without a question, the courts will begin to see the gross negligence standard being pushed to its limits. It will be interesting to see just how far it will go.

\textbf{D. The Exceptional Circumstances Exception}

Perhaps even more troublesome to physicians and insurers than the gross negligence exception is the exceptional circumstances exception, which gives the judge discretion to override the cap; how this will affect future lawsuits is somewhat unclear. The bill’s text reads:

Sec. 5.  
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2. In an action for damages for medical malpractice or dental malpractice, the limitation on noneconomic damages set forth in subsection 1 does not apply in the following circumstances and types of cases:

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\textsuperscript{59} Assemb. B. 1, § 5(6), 18th Spec. Sess. (Nev. 2002).


\textsuperscript{61} Id.

\textsuperscript{62} Id.
(b) A case in which, following the return of a verdict by the jury or a finding of damages in a bench trial, the court determines, by clear and convincing evidence admitted at trial, that an award in excess of $350,000 for noneconomic damages is justified because of exceptional circumstances.  

Therefore, the law allows for some flexibility and judicial discretion, although it is a high standard to meet (higher than the usual “preponderance of the evidence” standard in civil cases). In other words, the judge must be convinced that the evidence is “clear and convincing” that the case before him presents such an exceptional circumstance that the cap deserves to be removed.

Of course the exception leaves open a question of whether this standard is high enough to keep only those cases truly deserving to go beyond the damages cap. In testimony before the Assembly, Mr. Gillock voiced concern that malpractice suits involving death or loss of reproductive organs would be “subject to the whim of a judge who might be less than sympathetic to the losses.” These decisions would be poised against others from judges who are more sympathetic to the plaintiffs’ loss, and awards could become very inconsistent across the county. He argued that the exception would jeopardize the rights of citizens, especially in situations involving death and procreation.

Because the law is in its infancy, the Nevada Supreme Court has not yet addressed what type of case constitutes an exceptional circumstance under the clear and convincing evidence standard. However, it is clear from reading the legislative history of the bill, and the societal context in which it was created, that a judge would have to place a heavy burden on granting a motion to override the cap based on exceptional circumstances. The purpose of the law was to quell the amount of large verdicts in order to stabilize insurance rates. If a judge applied the exception liberally, the law would loose its teeth and there would be an abundance of cases lifting the cap contrary to the legislature’s intent. Furthermore, it would be a stretch to say that verdicts would be “subject to the whim” of a judge because the clear and convincing evidence standard is a serious and well-defined standard in American jurisprudence. It is unlikely that judges will take motions to exceed the damages cap lightly.

E. The Constitutionality of the Caps

The text of AB 1 was loosely based on California’s present medical liability regime, with numerous exceptions and differences. In the early 1970’s California faced a medical malpractice crisis similar to the one in Nevada. To combat the crisis and stabilize the system, the California...
Legislature enacted the Medical Injury Compensation Act of 1975 (MICRA).\(^6^7\) MICRA capped civil noneconomic damages at $250,000 without allowing for any exceptions such as the gross negligence and exceptional circumstances exceptions in AB 1. Because California has had the system in place for more than twenty-five years, and rates have appeared to stabilize as a result, it provided a good model to begin Nevada’s reform. Also, the constitutionality of MICRA’s cap on noneconomic damages was upheld in \textit{Fein v. Permanente Medical Group}, despite the plaintiff’s contention that MICRA abridged her due process rights by capping the amount of damages she could recover.\(^6^8\) The California Supreme Court held:

“It is well established that a plaintiff has no vested property right in a particular measure of damages, and that the Legislature possesses broad authority to modify the scope and nature of such damages.”

[T]he Legislature retains broad control over the measure, as well as the timing, of damages that a defendant is obligated to pay and a plaintiff is entitled to receive, and that [it] may expand or limit recoverable damages so long as its action is rationally related to a legitimate state interest. . . . [MICRA] is rationally related to legitimate state interests . . . in enacting MICRA the Legislature was acting in a situation in which it had found that the rising cost of medical malpractice insurance was posing serious problems for the health care system in California, threatening to curtail the availability of medical care in some parts of the state and creating the very real possibility that many doctors would practice without insurance, leaving patients who might by injured by such doctors with the prospect of uncollectible judgments.\(^6^9\)

Therefore, because MICRA provides an even stricter form of regulation than AB 1 (because it caps off at $250,000, and there are no exceptions), the bill’s proponents thought that it could survive a constitutional challenge in Nevada. The civil damages cap has also withstood the challenge that it violates a plaintiff’s right to a jury trial as provided in the California constitution, article 1, section 16, based upon the legitimacy of the legislature’s power to control the measure and timing of recoverable damages.\(^7^0\)

Courts in several other jurisdictions have upheld caps for noneconomic damages and, in some cases, even for caps on general damages.\(^7^1\) However, the constitutionality of damages caps have been struck down in a number of other jurisdictions, although many of the defeated laws

\(^6^7\) CAL. CIV. CODE § 3333.2 (West 2000).
\(^6^8\) 38 Cal. 3d 137 (1985), \textit{cert. dismissed} 474 U.S. 892 (1985) (The Court dismissed the appeal for lack of a substantial constitutional question).
\(^6^9\) \textit{Id.} at 158-59.
\(^7^0\) See \textit{Yates v. Pollock}, 194 Cal. App. 3d 195, 200 (Cal Ct. App. 1987) (the court held that while it was clear that MICRA would sometimes result in a lower recovery than would have been obtained before the cap, the legislature has the power to control the measure and timing of damages as long as it is rationally related to a legitimate state interest).
\(^7^1\) See, \textit{e.g.}, \textit{Etheridge v. Med. Ctr. Hosps.}, 376 S.E.2d 525 (Va. 1989); Williams v. Kushner, 549 So.2d 294 (La. 1989); Johnson v. St. Vincent Hosp., Inc., 404 N.E.2d 585 (Ind. 1980); Prendergast v. Nelson, 256 N.W.2d 657 (Neb. 1977); Samsel v. Wheeler Transp. Servs., 789 P.2d 541 (Kan. 1990); Franklin v. Mazda Motor Corp., 704 F. Supp. 1325 (D. Md. 1989) (the federal district court interpreted Maryland and United States constitutional provisions and upheld a $350,000 cap on noneconomic damages in personal injury awards, citing the fact that individuals had no vested interest in any rule of common law; therefore, the cap did not violate the right to a jury trial. Also, under state and federal due process scrutiny, the cap bore a reasonable relation to a valid legislative purpose); Boyd v. Bulala, 877 F.2d 1191 (4th Cir. 1989) (a federal court of appeals citing \textit{Etheridge} as dispositive of challenges made under Virginia’s state constitution as to a cap on medical damages, and finding no violation of the Seventh Amendment to the U.S. Constitution because the legislature may completely abolish a cause of action without violating the right of trial by jury and may permissibly limit damages recoverable for a cause of action as well).
included caps that applied to both noneconomic and general damages. Therefore, the future of AB 1 remains questionable until the issue is brought before the Nevada Supreme Court. Jim Crockett of the NTLA, introduced evidence before the Senate that directly called into question the constitutionality of passing a law that capped recoverable damages. He produced a graph that showed that, in the year 2001, insurance premiums for states without caps on damages for a general surgeon averaged $26,144, and the premiums in states with damages caps averaged $26,746 per year. He then questioned the connection between rates and the insurance industry because, according to his data, it was $650 a year more expensive to buy medical insurance in states with caps on damages. Crockett testified that the data showed that the blame for high insurance rates was on the insurers who were making bad financial investments, and not on excessive jury verdicts. The Texas Supreme Court noted a similar argument when it cited to a national independent study that concluded there was no relationship between a damage cap and increases in insurance rates (thereby reducing available health care), because less than .6 percent of all claims filed in court are more than $100,000.

One attempt to ensure the constitutionality of the bill was addition of the “exceptional circumstances” exception to its text to show that a judge has some discretion in determining the amount of damages to award, and that the $350,000 cap is not arbitrary. For example, during the second day of the 18th Special Session, the following exchange took place on the floor Senate floor:

**J. R. CROCKETT, JR. (NTLA):**

With regard to this language about exceptional circumstances, I think the drafter’s intention, probably, was to deal, in part, with the constitutional issues in order to avoid, at least as pertaining to this section, the contention that this law is arbitrary in setting a cap. By allowing a judge to exercise discretion in exceptional circumstances, it vents on some of that charge by allowing the judge to make a determination, in the judge’s discretion, that there are exceptional circumstances. Therefore the cap might otherwise be considered arbitrary and can be avoided in this particular case.

**SENATOR RAGGIO:**

Does anybody disagree with any of the statements being made to this committee at this time?

**MR. COTTON:**

No, we do not.

As with any piece of legislation, the constitutionality of AB 1 will remain questionable until it is challenged in court. First, a verdict or bench trial decision must be rendered in a medical malpractice case in which the noneconomic damage award exceeds the $350,000 cap. At that point, the judge will apply the cap, and the plaintiff will make a motion to lift the cap. The defendant will oppose this motion. If the judge denies the plaintiff’s motion to lift the cap,


74 Id.

75 Id.


77 Journal of S. of July 30, 2002, supra note 64.
or denies the defendant’s opposition to the plaintiff’s motion, the losing party may appeal the
decision to the Nevada Supreme Court for review. During this process, the appellant will argue
that the law is unconstitutional and that the district court judge’s ruling should be stricken. Only
at that time will Nevada truly decide whether the caps are constitutional.

The constitutionality of damage caps will likely be decided within the next few years,
especially because Nevada does not have an intermediate appellate system to bog down the
process. Until that decision from Nevada’s highest Court, any discourse regarding the
constitutionality of the bill is mere speculation. However, the bill is likely to pass constitutional
muster for several reasons. First, the legislature was clear that it understood that the bill’s
constitutionality was questionable, but expressed that it was passing it for a legitimate
governmental purpose: to ensure that enough health care providers remained in the state to
provide services for every citizen. Second, the legislature analyzed, in detail, California’s
present medical liability regime and determined that it was effective in solving medical
malpractice concerns such as those currently facing Nevada. That being the case, there was a
rational basis between the law and its desired effect, which is all that is needed. This is a
deferential standard which makes no requirement that the law actually work as intended, but
merely that there was at least a rational basis for the decision to pass the law. When the governor
of Nevada claims that the state is in a “crisis,” the Nevada Supreme Court is likely to find that a
chosen method of reform, which is supported by evidence that it works in states in which it has
been implemented, was a rational solution to a state emergency. Finally, the legislature took
progressive measures to ensure the law’s constitutionality, such as providing for exceptions and a
higher overall noneconomic damages cap than is provided in most states. For all of these
reasons, a challenge that AB 1 is unconstitutional is unlikely.

F. Are The Caps Effective?

Now that the caps have been imposed, the question is whether insurance rates will drop.
On January 30, 2003, Alice Molasky-Arman, Nevada’s Commissioner of Insurance, explained to
the joint Senate and Assembly committee reviewing her agency budget that the critical problem
of medical malpractice insurance availability was resolved, but that the affordability question
remained unanswered.\(^78\) Several months after the bill passed, many insurers refused to lower
premiums because of apprehension that the bill was unconstitutional and would not be held up in
court.\(^79\) Even in 2003, several insurers have been asking the Nevada State Division of Insurance
for rate increases. Early in 2003, the Division approved a twenty-five percent rate increase for
Physicians Insurance Company of Wisconsin and was considering a whopping ninety-three
percent increase from Continental Casualty Company.\(^80\) While it is comforting to some insurers
that damages caps without exceptions have survived legal challenges in some states, it is
troublesome that they have been struck down in other states.\(^81\)


\(^79\) Sean Whaley, Lawmakers Critical of Petition to Alter Medical Malpractice Law, LAS VEGAS REV.-J., October 4,

\(^80\) Joelle Babula, Some Worry Crisis Not Over as Insurers Seek Rate Increases, LAS VEGAS REV.-J., January 10,

\(^81\) See supra, Part III.E.
However, immediate results were not expected by the legislature, and the reform was meant to be a long-term remedy.\textsuperscript{82} Testimony before the Assembly revealed that Nevada could anticipate a four to five year waiting period before the insurance actuarial tables would reflect the provisions addressed by the bill.\textsuperscript{83} It was explained that there would possibly be some short-term savings and then there would be a wait for a pattern of cases and awards to build before there would be any significant movement in insurance premiums, which was not an abnormal result within the insurance industry.\textsuperscript{84} In fact, there was argument that even if the bill reflected a cap of $5, there would not be an immediate impact on premiums.\textsuperscript{85}

Therefore, it is probably still too early to decide whether the bill is accomplishing exactly what it set out to accomplish. It would be easy to criticize AB 1 as an ineffective means of dealing with the crisis because insurance rates have been slow to decline so far. Yet such criticism is premature because there have not been significant rulings on medical malpractice issues before the Nevada Supreme Court subsequent to the bill’s enactment. Thus, while knowing that most cases will be capped out at $350,000 is comforting to insurers, there has not been enough medical malpractice litigation since the reform to accurately adjust insurance rates. Unfortunately, Nevada will have to have patience before it may assert with confidence whether AB 1 was an effective remedial measure.

\section*{IV. Conclusion}

As the testimony from both sides of the debate showed during the Special Session, the damages cap has been hotly debated. People tend to either strongly support or disfavor caps, and that is putting it mildly. The hearings flushed out emotional testimony of horrendous stories of misfortune and injuries compounded by negligent physicians. There is a great level of trust that we, as vulnerable patients, place in our physicians to heal us and act with the utmost diligence. We trust that they will perform procedures with precision. We trust that they will analyze charts and symptoms with scrutiny and insight into our potential ailments. And certainly, at the very least, we trust that their conduct will not fall below the appropriate standard of care, which the average physician in similar circumstances would render. Unfortunately, the truth tells that this is not always the case.

However, national data shows that less than sixty percent of medical malpractice cases seek over $100,000 in noneconomic damages. As mentioned above, of the 158 medical malpractice cases filed in 2000, only sixteen actually went to trial.\textsuperscript{86} Of those sixteen, seven ended in a defense verdict, one case was dismissed, and another ended in a mistrial.\textsuperscript{87} Of the seven cases that ended in awards to plaintiffs, only three would have been capped by the new law – a small percentage. And thus, the inevitable balancing test: Is Nevada as a state, and we as citizens of that state, willing to see those cases capped based on the optimistic hope that insurance rates will drop and physicians will continue to provide quality health care? Is Nevada willing to accept that there will be a few unfortunate circumstances in which cases are capped, in exchange for the relief that its trauma center remains open to assist hundreds of victims of the

\textsuperscript{82} Minutes of Assemb. Comm. of July 30, 2002, supra note 41.
\textsuperscript{83} Id.
\textsuperscript{84} Id.
\textsuperscript{85} Id.
\textsuperscript{87} Babulla, supra note 5.
most gruesome injuries? The Eighteenth Special Session has shown that Nevada is willing, and has acted for what it believes is the best interests of all its citizens. It has at least attempted to provide exceptions to damages caps for the most unfortunate circumstances, subject only to judicial discretion. Only time will tell how effective and fair the new law will be. In the meantime, we must conclude that, at the very least, it was passed in an effort to ensure that a citizen of Nevada should never have to worry that she will be left without the possibility of treatment for herself and her loved ones. If for no other reason, that is deserving of support.

Epilogue: The Legislative Aftermath of AB 1: The New Focus On Insurance Reform

Nevada Assembly Bill 320 (“AB 320”) was a bill passed by the Nevada legislature in an effort to hold insurers partially responsible for the July 2002 medical malpractice crisis and to ensure that such a situation does not arise again. Throughout the debates of AB1, many testifying witnesses, mostly those from the NTLA, argued that insurers, not large jury verdicts, caused the crisis of 2002. Many argued that the key to the success of the medical liability solution in Nevada would be insurance reform. Legislators realized that not only was the medical profession in need of reform and new regulation, but so was the insurance industry. Thus, in May of 2003, we began to see the growth of insurance reform with the passage of several bills meant to add synergy to the inseparable role that insurance companies play with health care providers. Several other bills were passed during this term including Nevada Senate Bills 122 and 250, which made small changes towards insurance reform. The most significant bill was AB 320. The following is a brief outline and summary of the important changes.

Prohibition on Fees for Inclusion on a Panel of Providers of Health Care

Section 1 of AB 320 provides that if an organization establishes a panel of health care providers and makes a panel available for an insurer to use when offering health care services, or if an insurer establishes such a panel, that organization cannot charge a fee to the insurer or the provider of health care for including the provider’s name on the panel. If an organization violates this prohibition, it must pay the insurer or provider of health care twice the amount of the fee. In addition, a court must award costs and attorney’s fees to the prevailing party. This provision was meant to keep rates down and prevent collusion.

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91 Assemb. B. 320, § 1, 72d. Leg., Sess. (Nev. 2003). This section is similar to other prohibitions on panel fees under NEVADA REVISED STATUTES 689A.035 (Individual Health Insurance), 689B.015 (Group and Blanket Health Insurance), 689C.435 (Health Insurance for Small Employers), 695A.095 (Fraternal Benefit Societies), 695B.035 (Nonprofit Corporations for Hospital, Medical and Dental Services), 695C.125 (Health Maintenance Organizations), and 695G.270 (Managed Care).
93 Id. at §§ 1, 40.
Unfair Practices

Section 4 of AB 320 holds managed care companies accountable by specifying that failing to comply with the provisions of Nevada Revised Statutes Chapter 695G (Managed Care) is considered to be an unfair practice under Nevada Revised Statutes Chapter 686A (Trade Practices and Frauds; Financing of Premiums).94 Also, Section 29 holds health maintenance organizations accountable for bad business by subjecting them to the Unfair Trade Practices act above.95

Approval or Disapproval of Changes in Insurance Rates

Section 8 of AB 320 contains another important aspect of the bill that requires the Commissioner of Insurance to disapprove any proposal for an increase or decrease in rates that do not comply with Nevada’s standards.96 The bill is meant to give more control to the Commissioner in an attempt to stabilize the insurance industry in Nevada. In fact, the Commissioner must disapprove the proposal if she finds that a proposed increase will result in rates that do not comply with Nevada’s standards, such as rates that are excessive, inadequate, or discriminatory.97 Perhaps most importantly, Section 8 requires the Commissioner to disapprove proposals to increase the rate of insurance when the proposal was necessitated by fraud or imprudent investments.98 Some accusations fell on the insurers during debate of AB 1, mostly St. Paul, that the reason they had to withdraw from the market was due to poor investment choices. While not proven, there is certainly some validity to this possibility. Therefore, the legislature passed this law to prevent insureds from getting hit with high rates due to bad fiscal decisions.

Notice of Withdrawal from the Market in Nevada

A final monumental section of AB 320 was section 22, which requires an insurer with 40 percent of the market in Nevada for a particular category of practice to comply with certain requirements before withdrawing from that market.99 Specifically, the insurer must give at least 120 days notice to the Commissioner before withdrawing, and a withdrawal plan must be made in writing and approved by the Commissioner.100 This amendment was made to minimize the effect an insurer can have on the public in general and on the practitioners in a particular field. This amendment was also made to prevent situations as that which occurred in September of 2001, when St. Paul Company announced it had decided to leave the medical malpractice market nationwide, providing a catalyst for the crisis that was to build the following year. The rationale is that if the Commissioner has knowledge of such a withdrawal ahead of time, it can adequately attempt to fill the void in the marketplace left by the insurer.

The entire bill is quite comprehensive and includes forty-two sections. The sections outlined above will probably have the most effect on both insurers and health care providers. In

94 Id. at § 4.
95 Id. at § 29.
96 Id. at § 8.
97 Id.
98 Id.
99 Id. at § 22.
100 Id.
the following years, we will begin to see more regulation of both the insurance and health care industries to ensure that Nevada’s medical liability reform provides a treatment for the crisis in 2002, and not merely a temporary Band-Aid.